Buckhead Counseling, Psychiatry, & Psychotherapy

Scott Patterson, M.D., P.C., CGP, FAPA

Eleanor Brower, R.N., PhD, CGP

Directions: Please read these three pages; initial each page on the bottom right, and sign where indicated.

Date:____/____/____

CLIENT INFORMATION

Client Name: _____

(First) (MI) (Last)

Social Security Number: _____ Referred by: _____

Highest Level of Education:_____ Occupation: _____

In Case of an Emergency Call: _____

(Name) (Phone)

FINANCIAL POLICY

I understand that all charges are due at the time service is rendered and that I am responsible for all charges incurred. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR MISSED APPOINTMENT CHARGES UNLESS THE THERAPIST IS NOTIFIED 48 HOURS IN ADVANCE. Insurance does not cover missed appointments. Patients are responsible for the full fee (see last page).

Brief professional services and phone consultations will be billed at our standard rates in 15" increments. Some procedures may require our office staff or Dr. Patterson or Dr. Brower to provide exceptional services outside the normal visit. Please be aware that some, and perhaps all, of these type services may not be covered by insurance carriers if they do not consider them reasonable and necessary. You are responsible for all services not covered by your insurance company.

OUR OFFICE WILL NOT ENTER INTO A DISPUTE WITH YOUR INSURANCE COMPANY OVER YOUR CLAIM. OUR OFFICE WILL FILE YOUR CLAIM ONE TIME. You will receive a statement every month your account shows a balance due. In the event your insurance has not paid within 45 days; the balance will be transferred to your personal balance,

which must be paid before your next scheduled appointment. Your insurance policy is a contract between you and your insurance company; therefore, your balance is your responsibility.

INTEREST

We reserve the right to charge interest in the amount of 1.5% monthly (18% annually) as provided by state law on all past due account balances.

_____

Client Signature/Date

RE-FILING PROCESSING FEE

We cannot bill any insurance company appropriately without correct patient and insurance information. We ask that you provide insurance identification and patient information at your first visit and thereafter whenever there are changes. If claims are denied due to incorrect information, a $25 refiling fee will be charged to the patient.

MEDICATION REFILL POLICY

During your appointments, prescriptions for medications and refills are given in a supply sufficient to last until your next scheduled appointment, which should be made prior to your leaving the office.

If you do not make a future appointment at the time of your visit, it is necessary to call 2 weeks in advance of the time that you will be out of medication so that we can find an appointment time that will prevent your running out of medication. We will make every effort to find an appointment for you within those two weeks.

If there is a problem such as…loss of prescription, cancelled appointment, going out of town, forgetting to call, missed appointment, didn't call two weeks in advance…then Drs. Patterson and Brower will either wait until the next scheduled appointment to write your prescription (if clinically safe) or write/call in the prescription for a charge of $25 to cover phone and chart time.

RETURN CHECK FEES

A $35 processing fee will be charged for checks returned as insufficient funds, stop payment on an issued check and checks drawn on a closed account. This charge is applied to your personal account balance and must be paid within 14 days of notification to avoid further action.

*It is a criminal offense to present a check for payment that is drawn on a closed account.

Initials: _____

COLLECTION AGENCY

Our office will attempt to collect on past due accounts and returned checks. If our efforts are unsuccessful, we will forward your account to a collection agency for assistance in resolving these matters.

Thank you for understanding our Office Policies. Please let us know if you have any questions or concerns.

I have read and understand this Financial Policy and Medication Policy.

Signed: _____ Date: _____

Witness: _____ Date: _____

I voluntarily request counseling and understand that whatever I say in my psychotherapy sessions will be held in strictest confidence and will not be shared with anyone unless I give written consent to do so. However, as required by law, there are two exceptions to confidentiality in these sessions. These are: 1) if I disclose plans to physically injure or kill another person or myself, I understand my therapist is required by law to inform that person or the necessary authorities of my intent; 2) if I disclose that a minor child, adolescent, or elderly person is currently being physically or sexually abused, my therapist is required by law to notify the Child Protective Agency.

If I have a life threatening emergency I will call 911 or report to a hospital.

Signed: _____ Date: _____

Witness: _____ Date: _____

FEE SCHEDULE

Psychiatric Evaluation/Individual Psychotherapy

1. Dr. Brower (50 minutes): $200/$150
2. Dr. Patterson (50 minutes): $250/$200
3. Psychotherapy with Medication Evaluation (25 minutes): $100
4. Group Psychotherapy (90 minutes): $65

Initials: _____